Rehabilitation Services
Kansas Department of Social and Rehabilitation Services

Transition Notification
Referral for Vocational Rehabilitation Services

From: School _____
Address _____
Phone _____
Responsible Local Education Authority Staff _____

To: Local Rehabilitation Office Department for Children & Families
Address 1809 South Main Winfield, KS 67156
Phone 620-221-6400
ATTN: (Counselor Name) Peter Bishop

Student: Name _____
Address _____
Phone _____
Social Security Number _____
Birth Date _____
Expected Date to complete or exit school _____

Notification Accompanied by:

- Signed release of information
- Current IEP
- Current Three year evaluation
- Psychological testing information as recent as age 16 if available.

CONSENT FOR REFERRAL/RELEASE OF INFORMATION

Below is the signature authorization for _____ to be referred for Vocational Rehabilitation Services. I hereby consent to the release of the information to be sent to Rehabilitation Services for vocational rehabilitation planning.

Signature of Student _____ Date _____

*Signature of Parent/Legal Guardian (if appropriate) _____ Date _____

*If signed by parent/legal guardian, please provide address and phone number if different than the student's.

Address: _____

Phone: _____

Reasonable accommodations needed: _____